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Controlling Tobacco and Promoting Healthy Diets

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Every region of the world is facing a dramatic change in disease patterns as populations have shifted toward less healthy diets, increased alcohol and tobacco consumption, and declining physical activity in many populations. As a result, non-communicable diseases (NCDs) are on the rise, including cardiovascular disease, cancer, diabetes, and chronic respiratory disease. NCDs are now responsible for over 70 percent of deaths worldwide, with more than one-third occurring in people under the age of seventy. Once considered diseases of the wealthy, over 85 percent of premature deaths due to NCDs now occur in low- and middle-income countries. Treatment for NCDs is often difficult, expensive, and lifelong. Turning to prevention, there is widespread recognition that four behavioral risk factors are at the root of the major NCDs—tobacco use, unhealthy diet, lack of physical exercise, and harmful use of alcohol—with growing recognition of the need to invest in prevention and protective factors, including structural and risk avoidance strategies.

Even as global attention has remained focused on infectious disease pandemics, human rights scholars and practitioners have increasingly emphasized the human rights dimensions of the NCD pandemic as a basis to develop laws and policies to address risk factors and prevent disease. NCDs are now widely perceived as a human rights issue because, due to preventable risk factors, they increasingly affect children and adults in their most productive years, leading to premature morbidity and mortality. State obligations arise because these preventable NCD risk factors are largely within state influence or control. States have a specific and continuing obligation to move as expeditiously and effectively as possible toward the full realization of the right to health and other health-related human rights. An understanding of these human rights obligations is evolving as scientific evidence on the effectiveness of public policies to prevent NCDs becomes stronger. The human rights-based approach to NCDs provides a framework for understanding how the full range of rights guaranteed under international law apply to this dimension of human health, ensuring concrete mechanisms for holding states accountable for action to address NCDs.

This chapter explores how human rights norms, principles, and mechanisms can be applied to NCDs. Part I addresses the history and current trends in the NCD pandemic, with a focus on the major risk factors of tobacco consumption and unhealthy diets, the evolving legal and policy responses to these health threats, and the rise of human rights in global NCD policy. With increasing attention to human rights in the NCD response,

Part II outlines the current human rights approaches to respecting, protecting, and fulfilling rights in NCD prevention and control, recognizing the importance of the right to health in facilitating corporate accountability for commercial determinants of health. Part III considers opportunities to strengthen the legal obligations on states to respond to NCDs—developing new treaties, examining emerging threats, and confronting novel legal challenges. This chapter concludes that human rights standards, in particular those relating to the right to health, provide a strong impetus for protecting individuals from commercial determinants of health to prevent NCDs.

I. The Increasing Global Health Challenge of the NCD Pandemic and the Evolving Global Health Policy Response

Recent globalizing changes have witnessed a dramatic increase in NCD incidence. These health harms are associated with various goods and industries, including the tobacco, alcohol, food, and beverage industries. The international community has responded to these rising harms by developing strategies as well as international standards that have brought human rights into the NCD response.

A. The Global Rise of NCDs

Traditionally understood in contrast to communicable diseases, NCDs tend to be diseases of long duration and are the result of a combination of genetic, physiological, environmental, and behavioral factors.[1] These chronic diseases were long ignored in public health efforts, partly because of lack of understanding of their origins, diagnosis, and treatment (Weisz 2014). After World War II, NCDs overtook infectious diseases as the leading causes of death in North America and Western Europe (Gostin and Wiley 2016). Yet, government action to address NCDs was largely an American phenomenon until the 1960s, after which other nations, including the United Kingdom and France, also began to respond to NCDs (Weisz 2014). Since the 1980s, there has been a dramatic increase in NCD incidence globally, largely attributed to widespread changes in living environments and consumption patterns. This period also marked a growing attention to these diseases, from international as well as domestic policymakers, leading to the common use of the term "non-communicable disease." The rapid rise of NCDs has been driven by commercial interests, where business activities—including the production and sale of tobacco, alcohol, and unhealthy foods and beverages—have had a dramatic impact on NCD risk factors throughout the world.[2]

[1] Given their long duration, NCDs are also known as "chronic diseases." While some have used the term "lifestyle diseases" to describe NCDs, this has a negative connotation and is not used here, as it wrongly suggests that individuals can easily choose and change their behaviors.

[2] Separately, as noted in Chapter 10, the commercial pharmaceutical industry has played a key role in securing access to safe and affordable medicines for NCDs, and it is increasingly argued that the pharmaceutical industry has a human rights responsibility in relation to the availability and accessibility of medicines to treat NCDs (Lee and Hunt 2012).

The term "industrial epidemics" has been used to describe the NCD harms associated with various commercial goods and industries. In industrial epidemics, the vectors of the spread of disease are not biological agents but transnational corporations. As the promotion of unhealthy products is increasingly regulated in high income countries, these corporations have sought new and expanded markets in low- and middle-income countries, where regulation is weaker or nonexistent (Moodie et al. 2013). As globalization in these industries has been driven by international free trade and foreign direct investment by multinational food manufacturers and retailers, domestic firms have followed the examples of multinational tobacco, food, and soft drink companies, driven by competition and learning from new market entrants (Traill 2017). This shift has also coincided in recent decades with advances in food processing technology, permitting the production of highly processed, long-shelf life foods and beverages suitable for export to distant markets—but often high in salt, sugar, and trans fats.

Thus, an important contextual factor in the NCD pandemic concerns the living environment—the conditions in which individuals are born, grow, live, work, and age. These social determinants of health—including poverty, unemployment, and housing insecurity—can impact health directly but also can indirectly impact health by shaping how people behave (Marmot et al. 2008). Individual behaviors have been exploited by the private sector in ways that have facilitated the rapid rise of NCDs. The term "commercial determinants of health" has come to be used to describe the strategies and approaches used by the private sector to promote products and choices that are detrimental to health and lead to industrial epidemics—including marketing aimed at people of lower economic status, such as smaller packets of cigarettes, ubiquitous processed foods, and cheaper "fruit drinks" with less fruit juice and high sugar content (Kickbusch, Allen, and Franz 2016).

B. The International Community Responds

The international health and development community has slowly but increasingly responded to NCDs in recent decades. Beginning in 1998, the World Health Assembly adopted a resolution calling on World Health Organization (WHO) member states to develop a global strategy for the prevention and control of NCDs (World Health Assembly 1998). This resolution led in 2000 to the adoption of the Global Strategy for the Prevention and Control of Noncommunicable Diseases and subsequent WHO action plans (WHO 2000). The start of the twenty-first century marked a new phase in the international response, with states employing international law—if not human rights obligations—to address NCDs through the 2003 Framework Convention on Tobacco Control (FCTC) (Roemer, Taylor, and Lariviere 2005).

Case Study: The Framework Convention on Tobacco Control

The FCTC is the first international legal instrument designed to promote multinational cooperation to reduce the growth and spread of tobacco consumption, with tobacco projected to kill over one billion people in the twenty-first century. While the

proposed treaty initially lacked political support at the global level, the support of a new WHO Director-General, Gro Harlem Brundtland, pushed forward negotiations on the FCTC. The mobilization and influence of civil society organizations, which came together as the Framework Convention Alliance for Tobacco Control (FCA), contributed significantly to the adoption of the FCTC, providing the influential participation of norm entrepreneurs with strong organizational platforms. The FCA brought together over two hundred nongovernmental organizations that not only influenced the content of the FCTC but also served as a critical force to counter powerful industry interests throughout the treaty negotiations. The FCTC was adopted by state consensus in the World Health Assembly in 2003 and entered into force in 2005, receiving wide recognition from almost all WHO member states. Since coming into force, the FCTC has provided authoritative guidance to governments seeking to create tobacco control laws and regulations and has been particularly helpful, as discussed in Chapter 8, in supporting and defending tobacco control measures in courts. However, the treaty was not an instrument founded upon human rights—although the preamble of the FCTC mentions the right to health. Despite this lack of a human rights foundation, the role of civil society in the creation and adoption of the FCTC, as well as the Convention's emphasis on civil society participation as a guiding principle essential in achieving its objectives, has set an important normative standard and an example for potential new standard-setting instruments regulating food, soda, alcohol, and other commercial determinants of NCDs.

Moving forward from the FCTC, other major NCD risk factors would not be regulated through binding international treaties, but rather addressed through nonbinding resolutions—including the World Health Assembly's Global Strategy on Diet, Physical Activity and Health (2004), Set of Recommendations on the Marketing of Foods and Non-Alcoholic Beverages to Children (2010), and Global Strategy to Reduce the Harmful Use of Alcohol (2010) (Magnusson and Patterson 2014). Through the 2011 UN High-Level Meeting on NCDs, the UN General Assembly adopted a resolution to encourage UN member states to implement cost-effective population-wide interventions to address the major NCD risk factors, including through regulatory and legislative actions (UN General Assembly 2011). Drawing on this international consensus in 2012, the World Health Assembly endorsed a comprehensive implementation plan on maternal, infant, and young child nutrition (WHO 2014), including a global target to stop any increase in children overweight by 2025. The World Health Assembly thereafter adopted the Global Action Plan for the Prevention and Control of NCDs 2013–2020 (Global Action Plan), formulating nine global targets on the four major NCD risk factors—tobacco use, an unhealthy diet, lack of physical exercise, and harmful use of alcohol. The Global Action Plan includes a menu of policy options and cost-effective interventions for NCD prevention and control. Ambitiously, the Global Action Plan sets a global target of zero increase in rates of obesity and diabetes to support the achievement of a 25 percent reduction in mortality from cardiovascular disease, cancer, diabetes, and chronic respiratory diseases by 2025 (WHO 2013). Drawing from a second 2014 UN High-Level Meeting to review global progress in responding to NCDs, the UN General Assembly adopted the Sustainable Development Goals (SDGs)

in 2015. Unlike the Millennium Development Goals, the SDGs, first introduced in Chapter 4, include a focus on NCDs, with all states pledging by 2030 to "reduce by one third premature mortality from non-communicable diseases through prevention and treatment" (UN General Assembly 2015, goal 3.4).

Implementing these evolving global strategies and best practices through domestic policy, there is increasing evidence that a range of government measures can be cost-effective in curbing risk factors and NCD incidence. Legal measures to control tobacco have been developed through taxation of tobacco products; smoking bans in indoor workplaces, public places, and public transport; mass media campaigns; and restrictions on tobacco marketing. Governments have also adopted measures recommended by WHO to improve diets, including the reformulation of processed foods to reduce salt consumption; bans on trans fats in the food chain; and effective taxation on sugar-sweetened beverages (World Cancer Research Fund International 2018). For example, Mexico introduced a tax on sugar-sweetened beverages in 2013, and following the success of this policy in reducing sugar consumption, other countries have undertaken similar measures (Baker, Jones, and Thow 2018). These government actions to address NCD risk factors have contributed to the realization of human rights as a basis for public health.

C. Bringing Human Rights into NCD Policy

There is an increasing global commitment to stem the global increase in NCDs, and human rights law has evolved to provide an important framework for assessing the rights and interests of those who are directly and indirectly implicated. Human rights have thus catalyzed political advocacy and framed health policy in responding to NCDs (Patterson et al. 2019). Through human rights, advocates saw an opportunity to "galvanize action toward meaningful change, broaden the number of actors and beneficiaries, and help strengthen the foundations for public health in the future" (Gruskin et al. 2014, 775).

The creation of an explicit, human rights-based approach to NCD prevention has developed through key global health policy documents. The WHO Global Action Plan for the Prevention and Control of NCDs 2013–2020 lists the "human rights approach" as one of its overarching principles for national policy (WHO 2013). Similarly, the 2016 WHO Report of the Commission on Ending Childhood Obesity notes that "[t]ackling childhood obesity resonates with the universal acceptance of the rights of the child to a healthy life as well as the obligations assumed by State Parties to the United Nations Convention on the Rights of the Child" (WHO 2016, 8).[3] Beyond children, the UN Global Strategy for Women's, Children's and Adolescent Health, which includes the health challenges posed by NCDs such as obesity, is explicitly rights based (WHO 2017). With the UN thereafter establishing an Interagency Task Force on the Prevention and Control of NCDs, the terms of reference for this Task Force affirm the right to health as a human right. In 2018, the WHO Independent High-Level Commission on Noncommunicable Diseases recommended that "all activities be framed within

[3] The Report cites General Comment 15 of the UN Committee on the Rights of the Child, which, as introduced in Chapter 3, interprets the child's right to health under the Convention on the Rights of the Child.

existing principles, including human rights—and equity-based approaches" (Nishtar et al. 2018, 13).

In 2018, the UN General Assembly held its third high-level review on NCDs, explicitly acknowledging for the first time the importance of human rights in the global response, with heads of state and governments committing to take "necessary measures to recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health across the life course" and to respect human rights obligations in scaling up efforts to address NCDs (UN General Assembly 2018, para. 28). This reference to "the life course" is significant because it recognizes that tackling the upstream determinants of health is crucial to reducing NCDs. In drawing attention to social determinants of NCDs, the UN General Assembly underscored the need for health policies to address the unique challenges posed by poverty, such as poor housing conditions and lack of social security, which in turn are associated with poor health outcomes later in life and across generations (Mikkelsen et al. 2019). By reasserting the importance of addressing health determinants alongside health care, these global health policy statements have provided a foundation for a human rights response to the NCD pandemic.

II. Human Rights and NCDs: Framing Norms to Respond to Commercial Interests

Because human rights are indivisible, interdependent, and interrelated, a human rights response to NCDs involves implementing economic, social, and cultural rights as well as civil and political rights. These health-related rights in the context of NCDs include the rights to health, food, education, privacy, and information; and freedoms of expression, association, assembly, and movement. In addition to these substantive rights, the human rights framework also recognizes a rights-based approach to health, including principles of participation, equality, and accountability. Where commercial interests have sought to appropriate the language of human rights to advance commercial goals, health-related human rights provide a path for resolving potential conflicts of rights: to implement and monitor human rights to protect public health, to support civil society advocacy against commercial determinants of health, and to facilitate human rights accountability for commercial interests.

A. Implementing and Monitoring Human Rights in the NCD Response

The right to the highest attainable standard of health, first introduced in Chapter 3, provides a foundation for framing policies to prevent and control NCDs. The UN Committee on Economic, Social and Cultural Rights (CESCR) does not use the specific term "non-communicable diseases" in interpreting the right to health in General Comment 14 (CESCR 2000), as it was drafted at a time when there was not yet widespread international attention on the global NCD pandemic. Moving forward from General Comment 14, more recent interpretations of the right to health have sought to

address NCDs explicitly, as seen where the Committee on the Rights of the Child has focused on obesity and "fast food" as threats to the child's health, providing a framework to regulate commercial determinants in implementing the right of the child to the enjoyment of the highest attainable standard of health (CRC 2013).

In implementing the right to health, the CESCR in General Comment 14 offers a comprehensive set of tools for addressing NCDs, emphasizing that the right to health is a broad human right extending not only to access to healthcare services but also to underlying determinants of health. This broad approach recognizes that laws and policies addressing NCDs should focus not only on regulating and ensuring access to health care and medicines but also on a wide range of underlying conditions in which people can lead a healthy life, such as access to food, nutrition, housing, safe and healthy working conditions, and a healthy environment. In addressing state obligations to assure these underlying social determinants of health, states bear obligations to:

- Respect the right to health, which requires the state "to refrain from interfering directly or indirectly with the enjoyment of the right to health" (CESCR 2000, para. 33). This obligation prohibits governments from taking actions that contribute to the NCD pandemic; for example, requiring divestment from state-owned corporations that manufacture tobacco, alcohol, and obesogenic products, such as palm oil or sugary drinks.[4] States must also avoid discrimination in the provision of state services, including health services to people living with NCDs. The obligation to respect also implies, for example, that procedures for the regulation of health-related rights organizations should not be unduly restrictive; the media should be able to report freely on government action (or inaction) to address NCDs; and there should be no undue limitations on the right to demonstrate peacefully regarding government responsibilities.
- Protect the right to health, which requires the state to adopt legislative, administrative, educational, and other appropriate measures to prevent third parties from interfering with the right to health (CESCR 2000). In the context of NCDs, this presents a vital state obligation to address commercial determinants of health, which includes the obligation of states to adopt legislation or other measures to regulate the tobacco, alcohol, food, and beverage industries, preventing them from infringing the right to health.
- Fulfill the right to health, which addresses the problem of inaction, requiring states to "adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures" toward the full realization of the right to health (Ibid., para. 33). This obligation requires states to progressively realize NCD prevention and control, including through the codification of legislation (including, for example, fiscal measures and urban planning controls) and the development of a health system so that information, treatment, and medication are available and accessible to all who need them (Patterson et al. 2019).

[4] Through the control of pension or superannuation funds, governments can also respect the right to health by disinvesting from private companies and industries that unduly contribute to NCDs.

These human rights dimensions of NCD policy are especially relevant for children, who are particularly vulnerable when it comes to exposure to unhealthy products, including tobacco, alcohol, and unhealthy diets. Children are more vulnerable to the negative effects of NCD risk factors, and, due to their ongoing physiological and cognitive development, have limited ability to decide what is in their own best interests (Gispen and Toebes 2019). Addressing the vulnerability of children, the Convention on the Rights of the Child (CRC) emphasizes that states should regulate the marketing of foods that are: high in fat, sugar, or salt; energy-dense; or micronutrient-poor, in addition to drinks containing high levels of caffeine (CRC 2013). Although human rights treaty law typically reflects generally worded obligations—without specific references to tobacco, unhealthy diets, and other NCD risk factors—the human rights framework provides evolving legal authority to safeguard a healthy environment for children.

In addition to the substantive rights guaranteed by international human rights treaties, the human rights-based approach places obligations on states in the process of carrying out NCD prevention and control. As described in Chapter 4, states must respect certain cross-cutting human rights principles—including equality and non-discrimination; participation and inclusion; and transparency and accountability—as illustrated within WHO policy by:

- The WHO Global Action Plan, which seeks to realize participation through the principle of "Empowerment of People and Communities" as one of its "Overarching Principles and Approaches," noting that "[p]eople and communities should be empowered and involved in activities for the prevention and control of noncommunicable diseases, including advocacy, policy, planning, legislation, service provision, monitoring, research and evaluation" (WHO 2013, 13).
- The WHO Noncommunicable Diseases Document Repository and Noncommunicable Diseases Progress Monitor, which upholds principles of transparency and accountability by providing for the periodic reporting of state responses to NCDs.[5]

Monitoring the implementation of the right to health, as introduced in Chapter 7, human rights treaty bodies are increasingly using other sources of international law and non-binding instruments to assess state policies and practices to prevent and control NCDs. Where the CESCR has specifically asked states to report on efforts to address tobacco addiction, the CESCR has used state compliance with FCTC obligations as a measure of state implementation of the right to health (Voon, Mitchell, and Liberman 2014). Similarly, human rights treaty bodies have referred to non-binding WHO guidance in reviewing state action on other commercial determinants of health, including reference to WHO's Set of Recommendations on the Marketing of Foods and

[5] What is missing from this WHO monitoring, however, is the formal submission of civil society "shadow reports," as introduced in Chapter 7, to alert WHO and member states if there are concerns about the accuracy of the state data reported. In assuring this monitoring and review, much can be learned in the NCD response from the experience of reporting on HIV/AIDS. Unlike WHO's NCD monitoring framework, the UN National Commitments and Policies Instrument, which is used to measure state action on HIV/AIDS, also captures the views of civil society organizations on key policy and process indicators, providing for the submission of civil society shadow reports if the government does not submit a report or if the state data is contested (Taylor et al. 2014).

Non-Alcoholic Beverages to Children in assessing state efforts to address diabetes, hypertension, and cardiovascular disease (Baytor and Cabrera 2014). Thus, by monitoring the implementation of the right to health and other health-related human rights, these international human rights treaty interpretations can provide necessary legal accountability for state obligations to regulate commercial determinants of health. Human rights implementation and monitoring in NCD prevention and control is pivotal, yet these human rights have increasingly been co-opted by commercial interests, seeking to appropriate the language of rights to undercut public health regulations.

B. Corporations Co-Opting Human Rights to Undercut Regulation

Human rights claims have been used to advocate for policy measures to address NCDs, but rights have also been appropriated by corporations to attack those same measures—as seen in corporate efforts to thwart the regulation of tobacco, alcohol, food, and beverages. Corporate opponents of regulation have argued that the regulation of commercial determinants of health is paternalistic and interferes with personal autonomy and commercial speech (Baytor and Cabrera 2014). Where public health regulations are seen to limit the individual liberty to undertake harmful behaviors, corporations have co-opted the language of rights to attack public health regulations.

In the long fight against smoking, the tobacco industry has invoked the rights to privacy, liberty, and self-determination in its campaigns against tobacco control. Smokers, backed by industry resources, have strategically claimed a "right to smoke." The tobacco industry has also invoked rights to property and economic rights to claim an unrestricted marketplace, claiming that regulation of tobacco advertising infringes on rights to free speech and intellectual property of the industry.[6] While the tobacco industry has sought to frame smoking itself as a "personal right," tobacco control advocates have sought to reclaim human rights for public health (Taylor and McCarthy 2020). Rebutting claims of "smokers' rights," these advocates have argued successfully that the addictive nature of tobacco limits individual freedom and undermines public health.

International human rights law supports the limitation of individual rights to protect public health. To justify this limitation of personal freedom, as first discussed in Chapter 2, a state must demonstrate that the proposed limitation is necessary to achieve the public health goal; must involve the least restrictive means available; and must be proportional to the benefit gained (ECOSOC 1985). Although restrictions on smoking in public places involve a limitation of individual rights, these restrictions can be justified as effective, proportional, and the least restrictive measure to address the public health threat of secondhand smoke (Dresler and Marks 2006). Thus, rather than infringing on rights, such restrictions can be recognized as necessary to realize human rights. Proponents of NCD prevention argue that the rising incidence of NCDs impacts human rights, in particular the right to health and other health-related human rights, in ways that directly implicate governments and demand government action (Meier 2005).

[6] While rarely successful, the tobacco industry has frequently claimed freedom of expression before the European Court of Justice, claimed trademark rights in attacking "plain packaging" laws before the Australian Supreme Court, and claimed expropriation of property rights before the World Trade Organization.

By focusing on the government duty to realize the right to health of the individual, the emphasis shifts from the individual's liberty to undertake unhealthy behaviors to the state's obligation to protect public health. Such an approach to the right to health seems paramount in light of the individual's vulnerability in a society that is driven by commercial interests.

Given the role of powerful corporations in opposing the regulation of NCD risk factors, governments need strong civil society support to push for national NCD policies.[7] Such civil society support, as introduced in Chapter 6, requires protections of freedoms of expression and association, both to advocate for laws and policies and to facilitate accountability for government action to regulate commercial determinants of health.

Case Study: Freedom of Association, Civil Society Support, and Rights-Based NCD Policy

Civil and political rights, including freedoms of association and expression, are essential to civil society efforts to advocate for NCD policies. In Mexico, the National Nutritional Alliance (Alianza por la Salud Alimentaria) was formed in 2012 to advocate for a tax on sugar-sweetened beverages to reduce child and adult obesity. Alongside nutrition organizations working to prevent NCDs, the Alliance included human rights organizations advocating for children's rights, water rights, development rights, the rights of farmers, and consumer rights. The Alliance used mainstream media coverage of demonstrations, forums, and other events to educate the public about the dangers of sugary drinks and the health benefits of a proposed tax on sugar-sweetened beverages, as exemplified by the advertisement in Figure 11.1. Overcoming industry opposition, the Mexican legislature introduced a tax in 2013, and it has proven successful in reducing the consumption of sugary drinks. Drawing on this success, a Colombian civil society organization, Educate Consumers (Educar Consumidores), launched a television and radio campaign in 2016 to reveal the quantities of sugar in certain sugary drinks. A Colombian sugary drink manufacturer tried to block this public health advocacy, initiating a complaint for "false advertising" with the Superintendency of Industry and Commerce, which ordered Educate Consumers to cease the campaign in all media and to seek prior review by the Superintendency of any further material relating to sugary drinks. However, Educate Consumers filed a petition with the courts, arguing that the Superintendency's decision interfered with their rights to freedom of expression and the rights of individuals to receive information about the health risks of sugary drinks. The Colombian Constitutional Court agreed, holding that the freedom of expression guaranteed in the Constitution extended to giving consumers information about the food they consume and finding that Educate Consumers was providing information rather than advertising.

[7] Human rights language and principles have been a normative catalyst for civil society action on tobacco control, with over 160 organizations from around the world adopting the 2018 Cape Town Declaration on Human Rights and a Smoke-Free World (World Conference on Tobacco or Health 2018).

Figure 11.1. "12 Spoonfuls of Sugar" Campaign Against Sugar-Sweetened Beverages, *Alianza por la Salud Alimentaria*, Mexico.

C. Industry Accountability for Human Rights

Human rights provide a way to frame government action and support civil society oversight to prevent and control NCDs; however, private industries are not formal parties to human rights treaties. Where commercial interests do not bear direct legal obligations under international human rights law, it has been necessary to develop new paradigms to facilitate human rights accountability for the industries most responsible for damaging public health through commercial determinants of health.

Even though they are not signatories to the human rights treaties, private actors nevertheless bear corporate responsibilities to "respect" human rights. As stipulated in the authoritative 2011 UN Guiding Principles on Business and Human Rights, the obligation to respect human rights implies an industry responsibility to ensure that human rights are not infringed by business activities (OHCHR 2011). This responsibility applies to all international human rights, including health-related human rights, limiting corporations where they are engaging in activities that harm the health of individuals. Along similar lines, the CESCR has recognized that the private business sector has responsibilities regarding the realization of the right to health and advises that states should provide an environment that facilitates the discharge of private-sector responsibilities (CESCR 2017).

These corporate responsibilities do not go as far as government obligations to respect, protect, and fulfill human rights; yet, they include a responsibility not to violate human rights through products that the industry brings to the globalized marketplace. This means that human rights—including the rights to life, health, and information—need to be respected in the production, marketing, and sales of commercial products.

Industries must respect human rights by providing information on the harmful risks of their products as well as reducing the harmfulness of those products. For the tobacco industry, the responsibility to respect makes a very clear and specific case: by producing, marketing, and selling a product that is deadly by design, providing no benefit while killing half of its consumers, the tobacco industry flagrantly violates its human rights responsibilities (Toebes 2018). Beyond the inherent deadliness of tobacco, a strong case can also be made against the food and beverage industries, given the dramatic impact that packaged food products, especially sugar-sweetened beverages, have on obesity and NCD incidence.

Beyond establishing these corporate responsibilities, it is necessary to facilitate corporate accountability for human rights violations. By enforcing human rights through litigation, as first discussed in Chapter 8, there have been evolving attempts to hold industries accountable for health-related human rights. For example, in 1999, several major tobacco companies were successfully sued in the United States for fraudulent and unlawful conduct, with the companies found liable for tobacco-related medical expenses.[8] Beyond litigation, human rights advocates have promoted accountability through corporate protests, counter-advertising, and boycotts. These formal and informal accountability efforts will be crucial in clarifying the implementation of human rights obligations to prevent and control NCDs in the coming years.

III. Emerging Efforts to Develop Rights-Based Policies to Respond to NCDs

Human rights obligations in the context of NCDs will need to be clarified further, and new sources of treaty law and emerging soft law are seeking to provide this necessary interpretation. Beyond legal obligations to respect, protect, and fulfill human rights in the context of NCDs, international law can speak to the rights-holders that require specific attention, health harms from the use of alcohol, and policy challenges under international trade law.

A. New Sources of International Law

The adoption of new international legal standards is vital for protection against commercial determinants of health. In exploring the possibilities of new standards, both hard and soft law options need to be considered to address NCDs.

1. New Treaties

International law is crucial to developing a comprehensive global response to the globalized spread of commercial determinants of health. Based on the experience of

[8] Similarly advanced in Canada in 2019, the Quebec Court of Appeals upheld a lower court decision that ordered tobacco companies to pay damages of about Canadian $17 billion, based on a class action of smokers seeking damages for addiction and smoking-related diseases. Moving beyond civil litigation, a Dutch criminal case against the tobacco industry was unsuccessful in 2018, but it has stirred considerable public debate on the legal liability of tobacco companies (Toebes 2018).

the FCTC as a legally binding instrument, there have been calls for new international treaties to regulate the larger set of commercial determinants of NCDs. A 2014 proposal for a "framework convention on healthy diets" has sought to encourage policymakers to build on the work of the UN to combat obesity. That proposal, which is not grounded in human rights law, contains a set of open-ended provisions on the promotion and protection of healthy diets (World Obesity Federation and Consumers International 2014). Moving forward from this in 2019, the United Nations circulated a draft treaty, "Legally Binding Instrument to Regulate, in International Human Rights Law, the Activities of Transnational Corporations and Other Business Enterprises," which has human rights implications for transnational corporations and other business enterprises working in the tobacco, alcohol, food, and beverage sectors (OHCHR 2019).

As with the FCTC, the engagement of a broad range of civil society organizations will be crucial in the development of new treaties to ensure that drafts are comprehensive and receive state support. If the treaties are negotiated under the auspices of WHO, it will be important that civil society organizations with UN consultative status are allowed to participate fully in the discussions, as they do in UN Human Rights Council discussions on health-related human rights. This inclusive negotiating process would permit the rights-based participation of UN-accredited health organizations, women's and children's rights organizations, faith organizations, labor organizations, and many other groups committed to the health of their constituencies.

Yet, following the development of formal legal norms in the FCTC, WHO has since sought to pursue "informal lawmaking" in response to NCDs, involving new forms, processes, and actors in the creation of global norms (Pauwelyn, Ramses, and Wouters 2014). While this reflects a shift away from binding treaty law, these non-binding standards have filled regulatory gaps, gaining extra force through the interpretations of human rights treaty bodies, and it will be necessary to consider how such "soft law" can support human rights in the NCD response.

2. Human Rights Soft Law

Beyond international treaties, more can be done to expand the guidance provided by the UN human rights system to define state obligations in the context of NCDs. As examined in Chapter 7, the UN human rights system aids in the interpretation of international human rights law through human rights treaty bodies, whose comments, observations, and recommendations seek to clarify specific aspects of human rights. Applied to the NCD response, human rights treaty bodies could issue General Comments or Recommendations—either with a general focus on commercial determinants of health or with a specific focus on NCD risk factors such as unhealthy diets. By providing authoritative statements on how human rights should be interpreted, implemented, and monitored, treaty bodies can better support global health efforts to address NCDs (Garde et al. 2018).

Given the particular vulnerability of children to the marketing of unhealthy food and beverages, the Committee on the Rights of the Child is well positioned to issue General Comments on the unique NCD risks faced by children. Drawing from existing WHO recommendations on children's health, a General Comment from the Committee on the Rights of the Child on healthy diets could clarify state obligations to respect, protect, and fulfill the child's right to health through reference to the Global Strategy on Diet,

Physical Activity and Health (2004), the Set of Recommendations on the Marketing of Foods and Non-Alcoholic Beverages to Children (2010), and the Global Strategy to Reduce the Harmful Use of Alcohol (2010). By referencing such authoritative global health documents in a General Comment, this interpretation of the CRC would provide a link between soft law guidance in global health governance and hard law obligations through human rights treaties.

Looking to collaborations with the larger UN human rights system, WHO could meet with the Office of the High Commissioner for Human Rights, human rights treaty bodies, special procedures mandate holders, and other relevant global health agencies (including UNICEF, FAO, and UNESCO) to convene an expert meeting to develop guidelines on NCDs, commercial determinants of health, and human rights.[9] Such a cooperative human rights collaboration would provide expert guidance on the application of existing human rights obligations to NCD risk factors and clarify, among other things, the obligations of states to protect rights-holders from commercial determinants of health.

B. New Rights-Holders Vulnerable to NCDs

Where scholars and advocates have progressively addressed the interaction between risk factors of NCDs and human rights for children, this could subsequently be expanded to consider the specific vulnerabilities of other risk groups. NCDs affect people throughout the course of their lives, and given that all people are rights-holders, it will be necessary to describe the wider range of rights-holders essential to the NCD response, including women, racial and ethnic minorities, indigenous persons, disabled persons, the elderly, and persons with low socioeconomic status.

The additional consideration of these new rights-holders could lead to the identification of specific vulnerabilities to NCDs. For example, research suggests that in some regions, women are particularly prone to waterpipe smoking (Khalil et al. 2013). In addition, there is ample evidence suggesting that persons with an intellectual disability and persons of low socioeconomic status are more likely to be constrained in engaging in healthy behaviors, and as a result, have greater vulnerability to commercial determinants of health (Dalstra et al. 2005). The vulnerability of individuals to NCDs in the context of risk factors is complex and merits further attention in research and practice.

C. New Efforts to Regulate Alcohol

While the harms of tobacco and unhealthy diets are well documented, there is increasing evidence of the global harms of alcohol, warranting future rights-based regulatory efforts. According to WHO analyses, the harmful use of alcohol is the leading risk factor

[9] As seen in rights-based communicable disease efforts, UNAIDS and the Office of the High Commissioner for Human Rights, as discussed in Chapter 10, convened a 1996 expert meeting to develop human rights-based guidance for states on HIV and AIDS (OHCHR and UNAIDS 2006).

for premature mortality and disability among those aged fifteen to forty-nine years, accounting for 10 percent of all deaths in this age group (WHO 2018). WHO's Global Strategy to Reduce the Harmful Use of Alcohol is currently the most comprehensive international policy guidance on reducing the harmful use of alcohol (WHO 2010). Building from this global health guidance, human rights instruments will be crucial to addressing the health harms of alcohol, in particular the CRC, given the overwhelmingly detrimental effects of alcohol on adolescents (Chapman 2016). Several provisions in the CRC are directly relevant to protecting adolescents from the detrimental effects of alcohol promotion, advertising, and sale—including provisions to safeguard the child's right to health and protect the child from harmful substances—and the Committee on the Rights of the Child could look to these provisions to interpret state obligations to develop legislative, administrative, social, and educational measures.

Given the significant impact of the globalized alcohol industry on public health and human rights, a strong case can be made for considering a Framework Convention on Alcohol Control. Similar to tobacco, alcohol is a psychoactive and dependence-producing substance, and regulating it in ways similar to the FCTC would provide a feasible international option for addressing this commercial determinant of health. Complementing the non-binding Global Strategy, proposals for such binding frameworks have been presented and discussed on several occasions by public health entities, experts, and advocates (Lancet 2007). The framing and adoption of a binding alcohol control treaty presents an important opportunity to ground the international regulation of alcohol in human rights law, thus protecting the interests and rights of vulnerable persons, including children, adolescents, the elderly, and persons of low socioeconomic status throughout the world.

D. International Trade and Global Health

Where states seek to regulate commercial determinants of health to prevent NCDs, it will be necessary to prevent these national efforts from being blocked by international trade law. Most states are already bound in their international trading arrangements by the agreement establishing the World Trade Organization (WTO)—including over sixty related trade agreements and dispute settlement decisions pertaining to goods, services, and intellectual property. Nonetheless, protecting and promoting public health is a legitimate concern for WTO members. Under the WTO Technical Barriers to Trade and Sanitary and Phyto-Sanitary Agreements, state action to protect health is a legitimate policy objective for regulating trade in commercial determinants of health. Although regulatory action to protect health is a legitimate policy objective under WTO agreements, this state authority to legislate and take other measures to protect public health is not absolute.

The primary objective of WTO agreements is to promote free trade, which may cover the trade of commercial determinants of health. Yet, the import of cheap food, tobacco, soda, and alcohol products creates incentives for unhealthy behaviors, leading to a rise in NCDs. (Cheap imports can also undercut local agricultural production, leading to decreased production capacity and greater dependency on food imports.) Despite these health harms, measures to regulate the importation of unhealthy products must

be carefully crafted to avoid conflict with WTO rules on free trade and the threat of an international challenge in the relevant WTO tribunal.

Human rights can support advocates in prioritizing health over trade to address NCDs. However, protecting and promoting health-related human rights in the context of commercial determinants of health will require multidisciplinary expertise in international trade, public health, and food policy (Thow et al. 2017).

Case Study: Turkey Tails in Samoa

In 2007, Samoa banned the importation of turkey tails (a cheap, fatty meat imported into many developing countries) as part of efforts to address NCDs in the country. However, the ban was lifted in 2011 during Samoa's accession to the WTO, following concerns that the ban limited free trade, as many other high-fat foods—imported and domestic—were still available for local purchase. A national working group was convened to study the policy options to replace the turkey tails ban, examining global and regional evidence-based recommendations to improve diets and prevent NCDs. The findings of the study were reviewed in consultation with the national working group on trade agreements, chaired by the deputy prime minister and including representatives from the ministries of trade, commerce, agriculture, finance, and health, before the recommendations were finalized. The recommendations included (1) implementing comprehensive fiscal policy measures, through both taxes and subsidies, to create incentives for healthy food production and consumption, based on a nutrient profiling model; (2) increasing consideration of nutrition in investments for agricultural production; (3) investing in the healthfulness of food sold in the informal sector, including training and certifying vendors; and (4) implementing a targeted fruit and vegetable support measure in social welfare benefits. To further NCD prevention, the government of Samoa in 2016 also increased the duty on tobacco and alcohol products and introduced an excise tax on sugar-sweetened items and certain salt products. After the complete ban on turkey tails was lifted, Samoa imposed a temporary import tax for several years, even as turkey tails have remained popular in Samoa.

Conclusion

The NCD crisis is one of the major global health challenges of this globalizing world, with the globalized sale of commercial determinants of health driving the global spread of disease and death. Through global health governance, there is growing recognition of this rising threat, leading to the adoption of strategies and programs targeting specific NCD risk factors. These global health policies are increasingly framed as human rights obligations. Yet, the adoption of binding treaties has thus far proven difficult, with the FCTC serving as the only legally binding instrument to directly address NCDs.

Human rights law offers an important framework for assessing how public health interests are implicated, supporting the development of future regulations of commercial determinants of health. In the context of responding to NCDs, health-related human rights are interdependent and interrelated, including the rights to health, food, education, privacy, and information and the freedoms of expression, association, assembly, and movement. New NCD laws and policies, including the regulation of tobacco and unhealthy diets, should be grounded in these human rights standards, providing a regulatory path to protect the most vulnerable. Given that children have limited autonomy to decide what is in their own best interests, they require specific protection in the context NCDs, for which the CRC offers an authoritative framework. Additional attention needs to be paid to the vulnerability of others in this context, including women, disabled persons, and persons with low socioeconomic status.

Human rights standards, in particular those relating to the right to health, provide a strong normative framework and political catalyst for protecting public health from commercial determinants of health and preventing the continuing rise of NCDs. Based on human rights law, governments are legally obligated to adopt measures to protect their populations against the harmful effects of unhealthy behaviors and products—including an obligation to regulate those industries that profit from NCDs. In turn, industries have a societal responsibility to consider the health of their products to ensure that they do not violate health-related human rights.

Questions for Consideration

1. How are NCDs driven by behavioral risk factors? How are those behaviors driven by structural environments? How are environments driven by commercial interests?
2. In what ways have international law and global policy instruments evolved in addressing NCD risk factors? How did initial legal efforts to address NCDs through the FCTC neglect health-related human rights obligations?
3. Why are human rights seen as necessary in supporting NCD policy? What human rights have been implemented in the development of rights-based policies to prevent and control NCDs?
4. What obligations do states bear under the right to health to prevent individuals from engaging in unhealthy behaviors? Why are children entitled to special protections under the health-related human rights?
5. Why should individual freedoms to engage in unhealthy behaviors be limited in order to realize public health imperatives to address the threats of tobacco and unhealthy diets? How can public health actions be undertaken in a way that is least restrictive of individual rights?
6. How have commercial interests sought to co-opt the language of "human rights" to undercut efforts to regulate NCDs? How have public health advocates sought to reclaim human rights for public health?
7. What human rights responsibilities do private commercial interests bear in the NCD crisis? How have advocates sought to facilitate corporate accountability for human rights?

8. The FCTC was uniquely successful in employing international law to address tobacco. How can the human rights system support additional international legal standards in response to other commercial determinants of health?
9. What human rights lessons from the tobacco, food, and soda response can be employed in responding to the rising NCD harms of alcohol?
10. How can states balance an international imperative for the free trade of goods under WTO agreements against national human rights obligations to protect public health from harmful products?

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